DOCUMENT RESUME

ED 258 101 CG 018 304

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TITLE An Interdisciplinary Supervised Student Program Focused on Depression and Suicide Awareness.
PUB DATE Feb 85
NOTE 30p.; Paper presented at the Annual Meeting of the National Association of Social Workers (New Orleans, LA, January 31-February 3, 1985).
PUB TYPE Reports - Descriptive (141) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Adolescents; Communication Skills; *Counseling Techniques; *Counselor Training; Depression (Psychology); High Schools; Identification; Interdisciplinary Approach; *Peer Counseling; Prevention; Program Descriptions; Program Development; *Suicide

ABSTRACT

This paper describes the development of one high school peer counseling program created in response to a number of adolescent suicides and attempted suicides. The formation and activities of the interdisciplinary team (school social worker, school psychologist, school guidance counselor, health education teacher, and students) to develop and coordinate the program are discussed. The selection of students to be peer counselors is described and essential elements of the program are summarized, including the seven basic program goals. Evaluation procedures and results are briefly noted. Peer counseling materials and services provided by the program are listed and training emphases are described, including counseling techniques, communication skills, and specific techniques for recognizing signs of suicidal intent. A case vignette is included to illustrate the dynamics of the program. The appendix contains descriptions of myths about alcohol abuse, the myths and facts surrounding suicide, and peer counselor forms, questionnaires, and guidelines from the program. (NRB)

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AN INTERDISCIPLINARY SUPERVISED STUDENT PROGRAM FOCUSED ON DEPRESSION AND SUICIDE AWARENESS

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

"Everyday, over one thousand young people in the United States attempt to kill themselves--and this is only the reported figure. Many experts believe that suicide is, in fact, the number one killer of teenagers in this country. Tragically, it is also the nation's number one preventable cause of death."[1]

In response to this particular problem and other facets of adolescent stress, a group of high school students, staff members, and administrators discussed the development of additional services that could be provided for the student population. An interdisciplinary team composed of a school social worker, a school psychologist and a school guidance counselor developed and coordinated a peer counseling program since 1978.

This program has evolved into a sophisticated training modality that has sought to create an attitude of awareness and to help alleviate certain stress in students' lives.

Some of the issues to be addressed will include counseling techniques, communication skills, philosophy, in addition to specific techniques for recognition of signs, clues, indicators as well as debunking of myths and mysteries of substance abuse, depression and suicide. We will discuss appropriate levels of peer counselor interventions as well as issues of confidentiality. We will also discuss peer supervision and relate anecdotal material.

[1]Griffin, Mary, M.D. and Felsenthal, Carol, Family Circle Magazine, March 8, 1983, pp. 31-34; 68-69.

AN INTERDISCIPLINARY SUPERVISED STUDENT PROGRAM FOCUSED ON DEPRESSION AND SUICIDE AWARENESS

The authors of this paper define peer group counseling as, "a process in which trained and supervised students offer listening, support, alternatives and other verbal and non-verbal interaction, and some advice, to students who refer themselves."[1]

The concept of peer assistance has a long and successful history as evidenced by such programs as Alcoholics Anonymous, Gamblers Anonymous, Weight Watchers and others. Certainly peer pressure is an important process long understood, and often used, in a multitude of group settings: scouting, schools, churches to foster control. Many studies indicate that peer counselors can deal effectively with the social and personal problems of their peers.[2] Certainly by adolescence the peer group has become one of the primary influences in the development of social values and behavior. The field of drug rehabilitation has long relied on peer intervention as a therapeutic modality in helping drug involved adolescents deal with their addiction.

Effective peer-counseling programs that work with drug using adolescents have been reported in many secondary schools across the nation.

In discussing the Blandensburg High School peer counseling program in Maryland, Alwine stated that, "The contribution of a positive peer model to the school environment can only be a positive force and another alternative to reaching understanding among a school population."[3]

"Students may not be learned in the various approaches to counseling but one important thing in their favor is that they know how to talk to other kids. They do it all day long in school, at home or in neighborhood hangouts. Peer counseling takes advantage of this "built in" reciprocity of youngsters, and provides training in active listening, understanding and group dynamics, decision making processes, clarification of values, referral procedures and availability of community resources."[4]

"A school peer counseling program does not need to, and in fact should

not, focus on drugs alone. There are problems which are not drug related but in some cases just as disruptive to functioning effectively in scholastic and social situations. There are many signals which indicate that a student is having difficulty coping with his life. The increased incidences of school dropouts, family break-ups, theft, vandalism, and violence, all point to problems unresolved and costly in terms of human potential.[5]

Historical Overview of the Program

During the school year of 1978 to 1979, a number of adolescent suicides and attempted suicides occurred in the student community of the Ridgewood School System. The community which included students, administrators and residents expressed a need for a preventive mental health program. As an outgrowth of these most unfortunate events, the concept to extend the school staff to reach out to various segments of the student population who ordinarily would not seek help, was developed.

A group of high school students, staff members, and administrations discussed the development of additional services that may be provided for the student population. An interdisciplinary team of high school staff members and students were selected to develop and coordinate a peer counseling program. The staff members involved were the school social worker, school psychologist, a school guidance counselor, and a health education teacher.

A committee which consisted of three students and included a school social worker, school psychologist, a high school guidance counselor and a health education teacher, arranged an appointment with the director and student members of a peer counseling service in Rye, New York. This meeting was very fruitful in that the original developers were able to question the students and director as to how their program began and how it was functioning, so as to learn from their successes and mistakes. There was enormous give-and-take between the student staff members and the three students on this committee. As a result of this meeting, we were able to learn from their program and the difficulties they had during their stages of development. With this invaluable information, we developed a

program designed for the needs of our community.

During the 1979-80 school year, the peer counseling program was initiated to help students come to grips with problems concerning school, home and those internal factors that prevent the realization of individual potential. The concept centered around students counseling other students under the guidance and supervision of school professionals.

Students who function as peer counselors are chosen on the basis of interest, response to a questionnaire, staff interviews, and successful completion of a four week course of training. In addition, parents must give written approval and participate in a training session. Parental participation is designed to enable them to understand their child's role and the impact peer counseling may have on family life.

The course which the prospective peer counselor must take focuses on the development of communication and listening skills. Peer counselor staff also educates the peer counselor how and when to make referrals to appropriate staff members as well as familiarize them with community resources that are available to the counselees. On-going group group supervision of peer counselors is provided on a weekly basis by the peer counselor staff. Individual consultation is available on an as needed basis.

Essential Elements of the Program

The essential elements of the program are the willingness of students to support and participate actively in such an effort, parental understanding and cooperation, and guidance and supervision by school professionals. The development of mutual respect and trust are necessary for a successful program. Another essential is the understanding, cooperation and acceptance by the school system.

Goals

Program goals include:

1. The development of a core group of trained students, derived from various segments of the school population, who will be responsible peer counselors

2. The development of a screening procedure which includes advice, input, and involvement of guidance counselors and other school staff.
3. The development and maintenance of an on-going training program.
4. The establishment of specific skill development goals for peer counselors. These include helping the peer counselor to strengthen interpersonal skills, to know when to refer, and to develop liaisons with the community agencies and professionals.
5. The establishment of guidelines detailing purposes and procedures.
6. The establishment of an on-going communication system for parents and faculty.
7. The provision for the availability of a trained faculty member during and after school and over summer vacations.

Evaluation Procedure and Results

On-going staff and student self-evaluation and subjective information from faculty and parents provide evaluation data which is used to improve the program. A questionnaire was developed and used as a screening tool.

Dissemination Materials and Services

The peer counselor materials which have been developed to date include the Peer Counselor Questionnaire, Parental Permission Form, Peer Counseling Guidelines (for counselors and staff), and a program description.

The program was recognized by the state as one of the model programs in New Jersey. It was presented by part of the staff and two peer counselors as one of the effective pupil personnel programs in the State.

In utilizing peer counselors for crisis intervention, counseling, etc. we have, in our training, used a rather eclectic approach. Our models have ranged from a 'concrete' hands-on, for example: giving information to a student about pregnancy testing clinics, to some in-depth theoretical approaches re: Freudian, Menninger, Durkhein, etc.

We have also worked with our counselors in helping them to define what their own adolescence is all about, so they can be better prepared to cope with and counsel their peers.

We have attempted to point out that adolescents have a tough time growing up and adjusting to the biological changes of puberty, to increasing peer pressures, to environmental overstimulation (the notion that they have to look like that model in the ad for jeans). In addition, we try to point out that adolescents face the pressures of moral and religious considerations. All of this occuring at the same time that the adolescent is coping with separation and loss - separations from parents and the nuclear family, and the loss of childhood. What looms ahead is entry into the world of adults. This is pursued, however, with a great deal of ambivalence. It is not accidental that when adults review their own development the one stage they are least likely to want to recall (or to re-experience) is typically the stage of adolescence.

In our training, we also try to point out the factors that social pressures upon adolescent appear to be increasing rather than decreasing, the poor economic structure, continual specter of the danger of nuclear warfare, environmental pollution, which can harm adolescents and their offspring. With all of the aforementioned, there are increased demands to produce, to be able to meet any and all competition which can leave many young people with a pervasive sense of not being able to measure up.

Therefore, it is not uncommon to find in the suicide notes left by adolescents, reference to deep feelings of social ineptitude. Our counselors are trained to recognize some of the signs and clues of depression, to be aware of the sense of being isolated, alone, and possibly rejected and the feelings that there seems to be no way to "turn things around." They are also made aware that feeling hopeless and helpless can engender a kind of "tunnel vision" in which various experiences tend to confirm for the isolated adolescent there may be no other option but suicide to end the intolerable emotional pain involved in living with such an exceedinly poor self-image.

We try through group and individual supervised counseling sessions to bring about a point of view that in our culture, we tend to approve of children but derogate adolescents, to belittle their appropriate fears and concerns. Adolescents need, as we all do, people to listen to them; to

nurture them, and, most of all, to be able to communicate with them. They also need the recognition that they are on the verge of adulthood, and that this is by no means an easy transition.

Our training also attempts to demythicize aspects of substance abuse and suicide, to help the counselors to understand the myths that surround the aforementioned subjects. (Listed in the appendix of this paper are the most commonly believed myths and the facts accompanying each fallacy.)

We also try to help our counselors to understand some of the aspects of suicidal behavior so they are better prepared to deal with the phenomena. For example, we teach that suicidal behavior always involves mutiple factors, no one behavior should be viewed in isolation. It is the clustering of these behaviors that is more likely to be significant. In order to determine a risk factor, our counselors are trained to recognize that if one or more of the following behaviors are in evidence, there would be a need for further exploration. Some of the behaviors are divided according to Schneidman's Forewarnings of Suicide:

- verbal - direct statements; "I wished I were dead."; etc.
- behavioral clues - any previous attempt; giving away prized possessions, etc.
- situational clues - family strife; losses, etc.
- symptomatic clues - depression -- the obvious signs, plus supervised discussion re: the more subtle ones. (For an in-depth review of the material, refer to the index.)

Finally, in summary, we attempt to train our counselors to understand the sequence of events that seems to lead an adolescent to attempt suicide, and these are:

1. A long history of problems not of the adolescent's own making.
2. A period when problems escalate.
3. Feels of despair.
4. New problems tacked onto existing ones that lead to progressive isolation from meaningful relationships.

5. The final phase of isolation shortly before the adolescent decides that death "...is the only way out."

Vignette

An example of a successful peer counselor intervention, which illustrates much of what this paper has discussed is examplified by the following:

> Approximately three months ago, a peer counselor was approached by a fellow student, who expressed concern about a friend. The peer counselor in turn, encouraged the student to share specifics. Some of these included: distancing herself from formerly close friends, abrasiveness, a suspicion of substance abuse.
>
> Upon hearing this information, the peer counselor discussed this in group supervision. At that time, an intervention strategy was suggested:
>
> 1. The peer counselor was to enlist the assistance of the concerned friend in order to establish contact with the troubled person.
> 2. Once contact has been made, the peer counselor will evaluate and assess the situation, and report back.
>
> In the process of evaluation, the counselor perceived, accurately, the severity of the situation. She stated that there were definite signs and clues that indicated self-destructive tendencies, i.e., verbally: the troubled girl stated on more than on occasion that she didn't see a future. She also stated that no one cared about her, and the only time she felt good was when she either drank or smoked pot.
>
> The counselor, by utilizing the counseling skills she had been taught, was able to engage the troubled girl in tentative alliance and from there she was able to encourage and support her to maintain contact, which included: phone calls in the evening and on weekends and contact during school.
>
> After a relatively short period of time, the counselor was able to have the student meet with one of the program supervisors. Although the supervisor was instrumental in getting the girl and her family into a mental health center, it was the initial work by the peer counselor that not only "opened-up" the case, but in utilizing what she had been taught and the supervisory experience, was able to prevent a possible tragedy.

ENDNOTES

[1] Mimi Samuels and Don Samuels, The Complete Handbook of Peer Counseling. (Miami: Fiesta Publishing Corp., 1975), pp. 41-42.

[2] Ibid.

[3] G. Alwine, "If You Need Love Come to Us....An Overview of a Peer Counseling Program in a Senior High School." The Journal of School Health 44 (1974), pp. 463-464.

[4] Mimi Samuels and Don Samuels, The Complete Handbook of Peer Counseling. (Miami: Fiesta Publishing Corp., 1975), pp. 41-42.

[5] Ibid.

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APPENDIX

SOME POINTS TO CONSIDER REGARDING SUICIDE

1. Every year, suicide accounts for more than 20,000 to 35,000 deaths in the United States -- the 9th leading cause of death. It ranks second as a cause of death for adolescents and college students -- after accidents.
2. Although the death rate has remained relatively stable over the past decade, suicide threats, drug overdosages, and other forms of self-destructive behavior have increased dramatically.
3. Most common form of attempted suicide -- sedatives or hypnotic drug.
4. In addition to actual attempts, there are numerous threats and gestures.
5. Suicidal behavior is also encountered in conjunction with other crises:

   Alcohol
   Drug Abuse
   Family Crisis
   Acute Psychotic Reactions

6. In general: Suicidal reactions are associated with feelings of HOPELESSNESS and HELPLESSNESS.

   This is often related to the separation or loss of significant or valued relationship.

   Suicidal behavior can perhaps best be understood as an EXPRESSION OF INTENSE FEELINGS WHEN OTHER FORMS OF EXPRESSION HAVE FAILED.

   The expression of feelings can range from POIGNANT CRIES FOR HELP to desperate STATEMENTS OF DESPAIR.

7. The suicidal person is driven to this act because he/she feels unable to cope with a problem and believes that others ARE NOT perceiving or responding to his/her need.

   Thus, suicidal behavior may become a plea for attention.

8. Only a small number -- perhaps 10% of people who threaten or attempt suicide actually succeed.

FOREWARNINGS OF SUICIDE

Shneidman (1965) groups signs or clues of suicide, into four broad areas: Verbal, Behavioral, Situational, and Syndromatic.

1. Verbal: direct statements -- "I wish I were dead!", "I'm going to end it all....!", "No one cares!"

2. Behavioral clues:

   a. Any previous attempts.
   b. The professional should not be misled by: "I didn't mean to say it!" or "I only wanted the attention!"
   c. Subtle clues:

      - Making a will,
      - bequeathing one's body or organs to science,
      - giving away prized possessions,
      - setting one's affairs in order.

3. Situational clues:

   a. Family strife.
   b. Financial difficulties.
   c. Mutilative surgery can lead a person whose spirit is weakened or whose self-esteem is low to contemplate suicide.
   d. Losses: job, friend, pets, family member, relationships, change of address, divorce.

4. Syndromatic clues:

   a. Depression - the most prevalent syndrome.
   b. Disorientation - those who respond to delusional voices to destroy themselves.
   c. Defiance - individuals who insist on controlling their own destinies, including their own deaths.
   d. Dependence--dissatisfaction - people who perceive themselves as trapped in a hopeless condition.

The American Association of Suicidology (1977). Merck, Sharp and Dohme, Division of Merck and Company, Inc., West Point, PA 19486: list five significant suicidal signals:

1. Suicide threats or similar statements.
2. An attempt at suicide.
3. Prolonged depression.
4. Dramatic changes of behavior or personality.
5. Making funeral arrangements.

The general explanation for an incomplete or partially effective suicidal act is that the individual was filled with contradictory feelings about living and dying -- this is called AMBIVALENCE and is a universal trait -- not a weakness.

Some means of gathering information Re: suicidal potential:

1. Age -- older males -- high risk adolescents
2. Sex -- women attempt suicide more often than men. However, men commit suicide more often than women.
   What can start out as a manipulation can end up as a suicide.
3. Plan --
   Lethality
   How available are the means
   How specific
4. Stress --
   Generally -- a response to loss: death, divorce or separation, loss of job, money, prestige or status, health -- sickness, surgery -- self-esteem.
5. Symptoms:
   Typical: severe depression -- loss of appetite, weight loss, sleeplessness, interest -- withdrawal, apathy, etc.
   Tension
   Alcohol
   Addictive behavior
   Agitation -- person who is both depressed and agitated is particularly a risk -- They generally cannot tolerate the pressure of their feelings and generally show marked tension, fearfulness, restlessness and pressure of speech. They may eventually reach a point where they must act in some direction to relieve their feelings.

6. Life Style --
    a. Stable
    b. Unstable
    c. Is suicidal behavior acute or chronic
7. Communication aspect --
    - Whether or not communications still exist between the suicidal person and others
    - Can be verbal or non-verbal
      "Action Communications"
    - "Significant Other"
8. Medical status:
    - Chronically ill, etc.

SUMMARY: Of the above factors for determining suicide potential, one should be considered especially dangerous or alarming: having a specific plan, utilizing a very lethal method.

OTHER FACTORS

ADOLESCENT TURMOIL

1. Rejection -- masculinity -- femininity
2. Impulse
3. Alcohol abuse
4. Living up to high standards of family

REACTION IN LATE ADOLESCENT

A reaction of inadequacy and loss is often related to leaving the family and going away to school. Epitomized in plea, "I can't live without you."

MYTHS ABOUT ALCOHOL*

It has been relatively few years since scientists have begun to look closely at alcohol and the effects that this substance has on the human organism. Many of the things we currently believe about alcohol are, therefore, things that have been passed down to us through the countless centuries since alcohol was first used by human beings. It is only natural that some of our beliefs would fall into the category of myths rather than scientific fact.

Listed below are some of the more common myths. You may want to look at other things you believe about alcohol in light of current research.

A. ALCOHOL AND PERFORMANCE

I drive better after a few drinks. Alcohol does not normally increase physical or mental skills. What it may do is increase confidence and decrease judgment and self-criticism. The drinker may feel as if his performance has improved when in reality it may have declined. At least half of the fatal highway accidents involve drinking.

Alcohol increases sexual desire and ability. Contrary to popular belief, the more you drink, the less your sexual capacity. The depressant action of alcohol lowers inhibitions. Therefore the drinker may respond more freely to sexual stimulation. But, like other activities, too much alcohol reduces performance abilities.

B. ALCOHOLISM

I don't know any alcoholics. Maybe you just don't know any alcoholics. Some of your best friends may have drinking problems. They don't seem "different," and they usually try to hid their illness, even from themselves. About one of every ten people who drink has a drinking problem.

---

*The "Myths About Alcohol" are from "Here's Looking At You, a Teacher's Guide for Drug and Alcohol Education, Comprehensive Health Education Foundation, Seattle, WA 98288.

Most alcoholics are skid row bums. Alcoholism shows no favorites. It is found among all classes of people. It has been estimated that only three to five per cent of all alcoholics live on skid row. Furthermore, it seems that only a minority of those living on skid row are alcoholics.

You're not alcoholic unless you drink a pint a day. There's no simple rule of thumb. Experts have concluded that how much people drink may be far less important than when they drink, how they drink, why they drink, and what happens to them when they drink.

Most alcoholics are middle-aged or older. A University of California research team has found that the highest proportion of drinking problems is among men in their early twenties. The second highest incidence occurs among men in their 40's and 5[illegible]s.

Alcoholics are morally weak. Although there are still people who disagree, alcoholism has been medically and legally classified as an illness. Alcoholics are no more responsible for their drinking than tuberculosis patients are for their coughing.

All alcoholics drink in the morning. Although the craving for a morning drink is a common symptom among chronic alcoholics, there are those who don't display it. It is not when drinking occurs, but the lack of control over it when it does occur that defines alcoholism.

You can't become an alcoholic by drinking only beer. Even though the percentage is relatively low (2% - 5%), beer still contains the potentially addicting ingredient--ethyl alcohol. People who drink beer merely have to drink more liquid to get drunk than they would wine or whiskey.

Alcoholics drink every day. Some alcoholics drink only on weekends, some abstain for months. Alcoholism is not determined by how often people drink, but whether or not they can control their drinking once they start.

Women don't become alcoholics. Women do become alcoholics, but are not as likely to be diagnosed as such, since they are more easily camouflaged by the protective setting of the home. During recent years, the estimated ratio of men to women alcoholics has dropped from 6:1 to 3:1. The increase in the number of women alcoholics has been explained both as an increase in the willingness to be treated, and therefore "discovered," and as an increase in the actual number of cases.

I'm just a social drinker. Just because you never drink alone doesn't mean you can't have a drinking problem. Plenty of "social drinkers" become alcoholics.

The really serious problem in our society is drug abuse. Right. And the number one drug problem is alcohol abuse. About 300,000 Americans are addicted to heroin, but about 9,000,000 are addicted to alcohol. It's not even close.

C. ATTITUDES ABOUT DRINKING

People who drink too much only hurt themselves. And their families, and their friends, employers, strangers on the highways and you.

Thank God my kids aren't on drugs! If they're hooked on drinking, they're on drugs. With nine million Americans dependent on alcohol, it's time we stopped pretending it isn't a drug. The kids' favorite drug is the same as their parents' favorite: alcohol.

"What a Man!" Still on his feet after a whole fifth. When we stop thinking it's manly to drink too much, we have begun to grow up. It's no more manly to over-drink than it is to over-eat. Often people who seem to be able to out-drink others are developing a tolerance for alcohol and become dependent on it.

Getting drunk is funny. Maybe in the movies or in jokes, but not in real life! Drunkenness is no funnier than any other illness.

D. DRINKING PATTERNS

If the parents don't drink, the children won't drink. Sometimes, but the highest incidence of alcoholism occurs among offspring of parents who are either teetotalers or alcoholics. Perhaps the "extremism" of the parents' attitudes is an important factor.

E. HANGOVERS

The best cure for a hangover is . . . . Everybody has a favorite, but they all have one thing in common: They don't work! What works? Preventive medicine. If you don't drink too much, you won't get a hangover.

F. PROPERTIES OF ALCOHOL

Alcohol warms the body. Alcohol makes the drinker feel warmer because it causes blood to rise to the skin's surface. However, when this happens, the body temperature is actually lowered because the surface heat is lost.

Alcohol cures colds. Although some symptoms of the cold might be temporarily relieved, alcohol does not cure colds.

Eating foods made with alcohol can cause intoxication. When alcohol is used in cooking, little remains in the food as the alcohol evaporates when heated. Even if the alcohol is not heated, not enough is used to have any effects except for taste.

Mixing drinks causes greater intoxication. Only the consumption of ethyl alcohol, the ingredient common to all alcoholic beverages, causes intoxication, not the mixing of drinks. A person may tend to consume more when there is a variety of drinks, but it is still only the total amount of ethyl alcohol that counts.

Alcohol is a stimulant. Alcohol is about as good a stimulant as ether. Although in small quantities, it may be initially stimulating or irritating, it is primarily a depressant. The first area of the brain alcohol affects is the area which regulates inhibitions, judgment, and self-control. It is the lack of such restraints that causes the apparently "stimulated" or uninhibited behavior and people may do things they might not otherwise do.

People are friendlier when they're drunk. Maybe. But they're also more hostile, more dangerous, more criminal, more homicidal, and more suicidal. Half of all murders and one-third of all suicides are alcohol related.

Alcohol is a medicine. It is true that alcohol was called the miracle of life when the distillation process was discovered around the fourteenth or fifteenth century. These claims never held up, however, and there are currently very limited medical uses for this drug.

G. SOBERING UP

Black coffee and a cold shower will sober you up. Alleged methods for sobering up range from hot coffee to cold showers, from fresh air to food. The only effect any of these treatments can have is to produce a wide-awake drunk. An awakened drunk, feeling sobered up, may attempt to perform tasks, such as driving, of which he/she is no more capable than the sleepy drunk. Time is the only method of sobering up. There is no way to increase the oxidation rate--the rate at which the body eliminates alcohol.

MYTHS AND FACTS ABOUT SUICIDE

Everyday more than 1,000 young people in the United States attempt suicide - and this is only the reported figure. Many experts believe that suicide is, in fact, the number one cause of teenage death in this country. Tragically, it is also the nation's number one preventable cause of death. Suicide is a cry for help that backfires -- a cry for help that demands intervention.

All too often the adolescent's cry for help is not heard because of our own fear, superstition and the build-up mythology that has surrounded suicide for centuries. Books of mythology are generally taken as light reading, but believed myths surrounding suicide can literally be the difference between life and death. Most often when myths are exploded, the veil of ignorance is lifted, and denial is lessened. Listed below are some of the most comon fallacies about suicide as well as the factual responses based upon the most modern research.

1. **MYTH:** People who talk about killing themselves rarely commit suicide.

   FACT: Most people who commit suicide have given some clue or warning of their intent; therefore, suicidal threats and attempts should always be treated seriously. Also, of any ten persons who kill themselves, eight have given definite warnings of their suicidal intentions.

2. **MYTH:** If you ask a person about his suicidal intentions, you will encourage the person to kill himself.

   FACT: The opposite is true. Asking directly about suicidal intent will often lower the anxiety level and can act as a deterrent to suicidal behavior by encouraging the ventilation of pent-up emotions. A note of caution is also important: one should never pontificate about how much the individual has to live for, or how terrific he/she is, etc. The suicidal person has heard it all before and probably will not believe it. By attempting to make the individual "feel good" due to your anxiety and denial, matters can become much worse. It is far better to listen actively.

3. **MYTH:** Suicide happens without warning; it is a spontaneous activity.

   FACT: Studies reveal that the suicidal person gives many clues and warnings regarding his suicidal intentions. In fact, most suicidal people plan their self-destruction in advance and then present clues indicating that they have become suicidal. A case in point is the following poem written by a fifteen year old boy, two years before he committed suicide:

TO SANTA CLAUS AND LITTLE SISTERS

Once...he wrote a poem
And called it "Chops."
Because that was the name of his dog, and that's what
it was all about.
And the teacher gave him an "A"
And a gold star
And his mother hung it on the kitchen door, and read
it to all his aunts...
Once...he wrote another poem
And he called it "Question Marked Innocence."
Because that was the name of his grief and that's
what it was all about.
And the professor gave him an "A"
And a strange and steady look.
And his mother never hung it on the kitchen door,
because he never let her see it...
Once, at 3 a.m. ...he tried another poem...
And he called it absolutely nothing, because that's
what it was all about.
And he gave himself an "A"
And a slash on each damp wrist
And hung it on the bathroom door because he couldn't
reach the kitchen.

Other signs might include: giving away prized possessions; depression (or extended apathy); loss of appetite or increased eating; change in sleeping patterns; change of personality; verbalization ("What's the use, you won't be needing or seeing me around anymore."); change of lifestyle; increased drinking or drug abuse; withdrawal; etc.

4. **MYTH:** Suicidal people are fully intent on dying and feel that there is no turning back.

   FACT: Most suicidal people are undecided about living or dying. They are generally ambivalent and may gamble with death, leaving it to others to recue them. Almost no one commits suicide without letting others know how he is feeling. In fact, many people will call for help immediately following an attempted suicide.

5. **MYTH:** All suicidal people are deeply depressed.

   FACT: It is a fact that in 75 to 80% of all suicides, depression is a contributing factor. However, some suicidal people appear happier than they have been in quite a while because they have decided to "resolve" all their problems with a single act.

6. **MYTH:** Improvement following a suicidal crisis means that the suicidal risk is over.

   FACT: A very important time to be extra vigilant is when a depression is seemingly lifted and the individual appears to be at risk no longer. Many suicides occur within about three months following the beginning of improvement, when the individual has the energy to put his morbid thoughts and feelings into action.

7. **MYTH:** Once a person is suicidal, he/she is suicidal forever.

   FACT: Most people who are suicidal are that way for only a brief period in their lives. If attempters receive the proper assistance and support, they probably will never be suicidal again. Only about ten percent of attempters later complete the act.

8. **MYTH:** Suicide is basically a problem that is limited to people who are relatively young.

   FACT: Suicide rates rise with age and reach their peak among the elderly.

9. **MYTH:** There is a very low correlation between alcoholism and suicide.

   FACT: Alcoholism and suicide often go hand in hand. Alcoholics are prone to suicide and even people who do not normally drink will often ingest alcohol shortly before killing themselves. What makes alcohol dangerous in the adolescent is that not only does it increase depressive feelings, but can have the effect of increasing impulsiveness and utilization of very poor judgment. Developmentally, in adolescence one has remnants of magical thinking about his or her omnipotence and understanding of what death is. If one couples this developmental phenomenon with alcohol use, the combination can indeed be lethal.

10. **MYTH:** All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.

    FACT: Studies of hundreds of genuine suicide notes indicates that, although the suicidal individuals tend to be extremely unhappy they are not necessarily mentally ill. This statement, of course, does not apply to the truly psychotic or substance-induced psychotic.

11. **MYTH:** Suicide strikes much more among the rich or, conversely, it occurs exclusively among the poor.

    FACT: Suicide crosses all socioeconomic groups and no one class is more susceptible to it than another. The causes of suicide are many and varied including economic, political, sociological, psychological and cultural factors in any and many combinations.

12. **MYTH:** The tendency toward suicide is inherited and passed from generation to generation.

FACT: Suicide is not transmitted genetically, although it does tend to "run in families." What is also possible is that a young child in the development of his or her sense of identity may have a parent who is chronically depressed, or may have committed suicide, thereby setting the stage for self-destructive behavior in adolescence. This is caused, in great part, by identification with the suicidal parent or sibling and viewing suicide as the way out of problems. Additionally, if very young children are abandoned with no caretaker or significant other in their lives they, too, are at risk.

13. **MYTH:** Suicidal people rarely seek medical attention.

FACT: Research has consistently shown that about 75% of suicidal people will visit a physician about three months before they kill themselves. This fact, however, speaks to the inability of many professionals to recognize the signs of depression and to understand their own defense mechanism of denial.

14. **MYTH:** Professional people don't kill themselves.

FACT: Physicians, lawyers, dentists, and pharamacists appear to have high suicide rates.

15. **MYTH:** Because it includes the Christmas season, December has a high suicide rate.

FACT: There is not a rash of suicides at Christmas and December has the lowest suicide rate of any month. What seems to happen is that during the Christmas season, the depressed person feels some sort of belonging, through the extension of cheer via strangers. They feel things may get better. However, as spring comes and their depression does not lift by seeing rebirth and newness and freshness about them, they become more depressed and become overtly self-destructive. Actually, April is the month with very high rates of suicide.

These myths are some of the more significant that have been pervasive among the beliefs regarding suicide.

RIDGEWOOD HIGH SCHOOL
Ridgewood, New Jersey

PEER COUNSELOR QUESTIONNAIRE

This questionnaire is part of our screening process so fill it out carefully and thoughtfully.

NAME_____ HOMEROOM TEACHER_____

ADDRESS_____ HOMEROOM CLASSROOM #_____

HOME PHONE_____ GUIDANCE COUNSELOR_____

GRADE_____

---

1. Do you have sufficient available free time to full participate in the peer counselor training program and weekly supervisory sessions:

   YES_____ NO_____

   Are you willing to make a commitment for the Fall, 1981, and Spring, 1982, school semesters?

   YES_____ NO_____

2. Briefly let us know your reasons for wanting to be a peer counselor.

   _____

   _____

   _____

   _____

3. Are people currently using you as a counselor? Please, briefly, describe one experience you have had as a helping person.

   _____

   _____

   _____

   _____

4. On a scale of 1 to 10, with "1" being lowest and "10" being highest, how would you rate your credibility with your friends.

   _____

5. Do you feel people like you? YES_____ NO_____

   Why? _____

   _____

   _____

   _____

6. Do you feel people trust you? YES_____ NO_____

Why? _____

_____

_____

_____

7. How do you react when people get angry with you? _____

_____

_____

_____

_____

8. What are your two (2) biggest faults?

1. _____

_____

2. _____

_____

9. If you learned a friend was seriously planning to run away from home, what would you do?

_____

_____

_____

_____

10. If you learned a fellow student was talking about killing himself/herself, what would you do?

_____

_____

_____

_____

jh
10/27/81

RIDGEWOOD HIGH SCHOOL
Ridgewood, New Jersey

PEER COUNSELING GUIDELINES FOR PEER COUNSELORS AND STAFF

1. Peer Counselor contacts have limited confidentiality. Any conversation that includes a threat to harm oneself or another person is to be immediately reported to a staff member. The staff member will then help the Peer Counselor to take appropriate action.

2. All referrals that require staff intervention will be shared with the student's guidance counselor. The purposes of this sharing are:

    a. to avoid duplication of service or working at cross purposes;

    b. to allow the guidance counselor to inform the Peer Counselor of steps already taken and to provide feedback to the Peer Counselor for appropriate action.

3. Non-crisis interventions will be kept confidential and discussed in group or individual supervision sessions.

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RIDGEWOOD HIGH SCHOOL
Ridgewood, New Jersey

_____
(DATE)

I, _____, the parent/ guardian of _____, give permission for him/her to participate in the Peer Counseling Program at Ridgewood High School.

I (will) (will not) be able to attend the Parent-Staff-Peer Counselor meeting on _____ in _____.

_____
(Parent/Guardian Signature)

MF/pj